VERNON PARISH SCHOOL BOARD
Parent/Guardian's Request & Permission
(THIS SIDE TO BE COMPLETED BY GUARDIAN)

NAME OF STUDENT:_____ **DATE OF BIRTH:**_____

SCHOOL:_____ **GRADE:**_____ **TEACHER:**_____

NAME OF GUARDIAN:_____ **PHONE: (HM)**_____ **(WK)**_____

ADDRESS:_____

ALTERNATE CONTACT:_____ **PHONE:(HM)**_____
(WK)_____

RELATIONSHIP:_____

STUDENT ALLERIES:(List medication, food, insects, latex, etc.)_____

Parent/Guardian Consent
(NEW ORDERS REQUIRED FOR EACH SCHOOL YEAR AND AS ORDERS CHANGE)
I request that the trained school employee give the following:

_____ **To** _____
(Name of Medication-One per page) **(Name of Student)**

1. **I agree to provide the medication in a container labeled by the pharmacy specifically for the school time dose.**
2. **I request the school nurse share with the appropriate school personnel, physicians or medical facility, information relative to the prescribed medication administration as the nurse determines necessary for my child's health and safety.**
3. **I understand I may retrieve the medication from the school at any time and agree that the medication will be destroyed if it is not picked up within two weeks following termination of the order or one week beyond the end of the current school term.**
4. **I give consent for the school nurse to assess my child in the school setting to assure the safety of giving this medication at school.**
5. **I agree that the initial dose of ordered medicine was/will be given at home and I will observe my child 12 hours for adverse reactions before asking school personnel to administer the medication.**
6. **I agree that I, or a responsible adult, will bring the prescribed medicine to the school to observe and verify the count and receipt of the medication. Up to a 25 day supply can be stored at the school.**

NOTICE: USE THIS BOX ONLY FOR A STUDENT WHO WILL ADMINISTER HIS/HER OWN MEDICATION, SUCH AS AN INHALER OR EMERGENCY MEDICATIONS. STUDENT WILL BE REQUIRED TO RECORD EACH DOSE AT THE SCHOOL OFFICE.
1. Do you give permission for your son/daughter to self-administer medication if the school nurse determines it is safe and appropriate in the school setting? YES_____ NO_____
2. Do you feel that your child is sufficiently responsible and informed to administer his/her own medication? YES_____ NO_____
3. Do you assume responsibility for your child's actions in his/her self-management of medication at school? YES_____ NO_____

SIGNATURE OF GUARDIAN_____
RELATIONSHIP OF STUDENT:_____ **DATE**_____